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Breast Cancer Patients' Personality Style, Age, and Treatment Decision Making

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Background: Previous studies have shown that whereas nearly all cancer patients want information, far fewer wish to make treatment decisions. Although breast cancer patients who were given a choice of lumpectomy versus mastectomy and were encouraged to make the decision were believed to do better psychologically, a 1994 study refuted this. Some authors suggest that patient personality style is an important consideration in decisional preference.
Methods: Newly diagnosed breast cancer patients (n = 76) were surveyed within 6 months of surgery. They answered seven questions about patient and physician roles in the decision-making process. Additionally, they completed the Miller Behavioral Style Scale (MBSS), which categorizes "monitors," or information seekers, and "blunters," or information avoiders. Chi-square analyses were used to explore the relationship of personality style and age to treatment decision-making preferences.
Results: Although 80% of women wanted a role in decision making, 74% wanted their surgeons to make a recommendation and when given, 94% followed the recommended treatment plan. Monitors and blunters were equally likely to want physician recommendations. Younger women, particularly those under age 40, were more likely to want a physician's recommendation. Of those women who had specific fears about their cancer (76%), only half of them revealed such fears to their doctors.
Conclusions: The notion that health care consumers, particularly younger ones, desire an independent choice of treatment was contradicted in this study. Physicians are encouraged to provide information and to probe regarding the fears of breast cancer patients in order to reduce anxiety while recognizing that treatment recommendations are desired by most women.

KEY WORDS: **breast neoplasms, decision making, monitor vs. blunter**

INTRODUCTION

Data from clinical trials have shown that 80–90% of women can be offered the choice of either mastectomy or breast preservation with radiation therapy. Earlier studies of women randomized into treatment groups showed that those in the lumpectomy group had more psychological distress [1]. These studies concluded that a woman's psychological well-being was not related to the type of surgery but instead concerned whether she had been allowed to choose the surgery type herself. Fallowfield and colleagues [2], who noted that most cancer patients want information about their disease but did not wish to make treatment decisions, followed women for 3 years after

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surgery and found no evidence that women offered a treatment choice had fewer psychological problems.

Schain [3] proposed that physician-patient communication about breast cancer should be tailored to the patient's desire for, and ability to handle, information. This proposal drew upon the work of Miller et al. [4], who identified two coping responses of patients seeking information. "Monitors," or information seekers, seemed to benefit psychologically from data presented to them. "Blunters," or information avoiders, would rather not be told all the information relevant to their diagnosis, care, and treatment [4]. A study by Hack et al. [5] lends empirical support to Schain's proposal as some of their passive patients, presumably blunters, indicated that pressure to assume a more active role in treatment decision making was anxiety provoking. Hack and colleagues [5] suggested that physicians should respect patient preferences regarding information and participation in decision making. They further cautioned that patient preferences may shift depending upon the severity of the illness. Roberts et al. [6] advocated interactive physician-patient communication in the decision-making process with the physician attempting to elicit, understand, and respond to the individual patient's specific fears and concerns about breast cancer.

Other studies have focused on decision-making preferences and involvement in care among patients with different types of cancer. Cassileth [7] found that 25% of patients, particularly younger patients, wanted active involvement in decision making. Similarly, Blanchard et al. [8] reported that 92% of hospitalized oncology patients wanted all information to be given to them, whereas 69% wanted to participate in treatment decisions. Those who wanted the physician to make decisions tended to be older, sicker, married males, leading Blanchard and colleagues [8] to observe that these men may have been comfortable allowing their wives to act as brokers in the health care system. In contrast to these findings regarding age-related differences, Hack et al. [5] studied breast cancer patients and found that the relationship between age and preference for decisional control was not significant. Additionally, the relationship between treatment role preference (active vs. passive) was not related to illness severity or treatment procedure.

This study addressed the following research questions: (1) do breast cancer patients want an active role in choosing their treatment plan and what role do they want their physician to assume? (2) do monitors and blunders differ in their desired patient and physician roles in decision making? (3) is age a predictor of patient preferences in decision making? (4) do patients reveal specific fears about breast cancer to their physicians?

MATERIALS AND METHODS

The study design consisted of 76 women (average age 54.6, SD = 13.71) treated by academic surgeons at the H. Lee Moffitt Cancer Center and Research Institute (Tampa, FL). Patients underwent a lumpectomy (36/76, 47%) or mastectomy (40/76, 53%) for treatment of breast cancer. Of these women, 68% (52/76) were married. After giving informed consent, 45/76 patients (59%) were interviewed in person during a postoperative follow-up visit, which occurred within 1 month of surgery. The remaining 31/76 (41%) were contacted via phone interview and mailing. The average period elapsed since surgery was 1.26 months.

Subjects completed a seven-item questionnaire that probed the decision-making process used by the surgeon and patient to arrive at their treatment plan. Patients also completed the Miller Behavioral Style Scale (MBSS) to classify individuals as using either monitor or blunter coping styles [4]. Miller et al. [4] offer several alternatives for scoring the MBSS. Patients who scored above the median on the monitor subscale and below the median on the blunter subscale were classified as monitors. Conversely, those scoring above the median on the blunter subscale and below the median on the monitor subscale were classified as blunters. Cross-tabulation analysis was then used to compare these two subsamples on their decision-making questionnaire answers.

RESULTS

Although 79.7% of women wanted a role in the decision-making process, 73.6% of those in the study wanted their physicians to make a recommendation (Table I). Among women given a recommendation the overwhelming majority (93.8%) followed the physician's treatment plan. When asked if they had specific fears about facing breast cancer, 76.3% of women responded yes, but only 55% of these women actually told their physicians or other health care providers about these fears. For example, these specific fears included anxiety about losing a breast, chemotherapy, and fears of dying before their children are grown. Consequently, 45% of women had their fears unrecognized by a health care provider and thus could not be offered counseling.

Although previous work by Miller et al. [4] attempted to categorize patients as either monitors or blunters, these data show that only 38/76 (50%) of patients could be distinctly placed in either category. The remaining 38/76 (50%) of patients employed a combination of both coping responses. Using the criteria outlined above, only 15 of 76 (20%) patients could be categorized clearly as monitors and 23 of 76 (30%) as blunters. Surprisingly, blunters were not more likely to desire a physician's recommendation. Both monitors and blunters were equally likely to have specific fears about facing breast cancer, and monitors were no more likely than blunters to tell their physicians of their fears (75% monitors vs. 47.3% blunters, not statistically significant).

To explore age-related differences, the sample was split at the median age to compare patients age 53 and over

TABLE I. Frequency of Yes Responses to Questions About Decision Making (n = 76)

Question:	n	Percent
Did your physician encourage you to help decide tx?	59	79.7%
Did you want a physician recommendation?	53	73.6%[a]
Did you get a physician recommendation?	50	65.7%
Did you follow the physician recommendation?	46	93.8%[b]
Did you have specific fears about facing breast cancer?	58	76.3%
Did you tell your physician about your fears?	31	55.3%[b]

[a]Percentage calculated w/o n = 4 nonrespondents to this question.
[b]Percentage of subjects who answered yes to the previous questions.

to those age 52 and under. According to the patients' reports, physicians were equally likely to make treatment recommendations to both older and younger patients. However, women age 52 and under were more likely to want their doctors to make a recommendation (Chi square 5.14, df 1, $P = .023$). Visual inspection of the data shows that all of the women age 40 and under (n = 14) wanted a physician's recommendation. Older women were less likely to have specific fears about facing breast cancer (Chi square = 13.33, df 1, $P = .0002$).

In response to the question "What suggestions would you make regarding the doctor's or patient's role in making decisions about the type of surgery?" 32% of patients suggested that physicians should educate their patients more about breast cancer so that they can make a more informed decision. One-quarter of subjects also suggested that patients should assume the responsibility of educating themselves in order to participate more effectively in decision making. An additional 21% believe physicians should spend more time with their patients.

DISCUSSION

Data from this study indicates that although breast cancer patients want an active role in the decision-making process and desire information regarding treatment options, they also expect a physician's recommendation and, when provided, will follow this recommendation 93.8% of the time. This is consistent with the research of Strull et al. [9], which indicated that patients seek information not to control their treatment outcome, but rather to reduce their anxiety and fear of the unknown. In this study, 76% of patients had specific fears about facing breast cancer, yet only 55% of these patients actually discussed these fears with a physician. Thus information seeking by patients may be an indirect attempt to resolve their fears surrounding their diagnosis, treatment, and outcome, without engaging in an emotional discussion of their concerns with their physicians. Physicians need to encourage patients to voice their fears, thus allowing them to be addressed with appropriate information and counseling. Additionally, common patient concerns should be routinely addressed with each patient diagnosed with breast cancer. A useful way to elicit patient fears is to ask, "Have you ever known anyone with breast cancer and what was the outcome?" Through this question, open communication can be facilitated and anxiety reduction may occur. Another question the physician might ask the patient is, "Are there specific aspects of your care or treatment options which you would like more information about?" Hack et al. [5] found that this patient initiated desire for knowledge enhances patient recall of information.

In our study, 74% of the patients wanted a physician recommendation, a figure that is in close agreement with the finding of Degner and Sloan [10] that 59% of newly diagnosed cancer patients wanted their physicians to make a treatment decision. Based on these results, we suggest that physicians ask, "Would you like me to recommend a treatment plan to assist in your decision making?"

In spite of the intuitive appeal of the monitor vs. blunter personality type, the data did not support the notion that a majority of patients fall clearly into one category or the other. Most patients used both monitor and blunter coping mechanisms. Among the clearly identifiable monitors and blunters, there was no significant difference in their desire for a physician's recommendation. Additionally, both monitors and blunters were equally likely to have specific fears about facing breast cancer and the monitors were no more likely to discuss these fears with their physicians. Consequently, in this analysis, patient coping styles had no significant effect on decision making.

A limitation of this study stems from the data collection procedure. Although a majority of subjects were surveyed soon after their breast cancer diagnosis and initial surgery, 27% (21/76) were surveyed between 3 and 6 months later, thus introducing the possibility of inaccurate recall of the interaction with their surgeons. In addition, administration of the MBSS during the period of emotional crisis surrounding the cancer diagnosis may not have provided the most valid representation of subjects' typical or noncrisis coping mechanism. For instance, in the study by Degner and Sloan [10], they showed that decision-making preferences were highly dependent on health status. Of the general public surveyed, while healthy, 64% said they would want to select their own treatment, whereas 59% of patients being treated for cancer stated they wanted the doctor to make treatment decisions on their behalf [10].

The observation that older women harbored fewer spe-

cific fears about facing breast cancer is consistent with previous studies showing that older individuals have dealt with more life crises and therefore are better equipped to cope with breast cancer [11]. Contrary to our expectations, the younger women were more likely to want a physician's recommendation, perhaps related to their being more fearful and consequently wanting more direction. Thus age is a predictor of patient preferences in decision making, although it should be considered along with other patient-specific variables in the decision-making process. Clinically, we suggest that younger women often desire more physician direction than clinicians might normally assume, whereas older women are more comfortable making treatment choices themselves.

CONCLUSIONS

Today's consumer-oriented health care movement has fostered the consensus that all patients desire choice and that the traditional model of physician-patient interaction should be abandoned. This research shows that although the majority of patients seeking care at a cancer center desire an active role in the decision-making process, many also want a physician's recommendation. Finally, most patients need education from their physicians and use this education to lessen anxiety about facing breast cancer.

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